Eugene Holistic Medicine

New Patient Wellness Intake

All Information is Strictly Confidential.

Name_____ Date of Birth_____

Address_____City/State/Zip_____

Phone:(H)_____ (W)_____ (C)_____

Email _____Occupation_____

Whom may we thank for your referral? _____

Please take a moment to answer the following questions:

Have you had acupuncture treatments before? ❑Yes ❑No *When?* _____

What are your particular goals for this acupuncture session?

_____

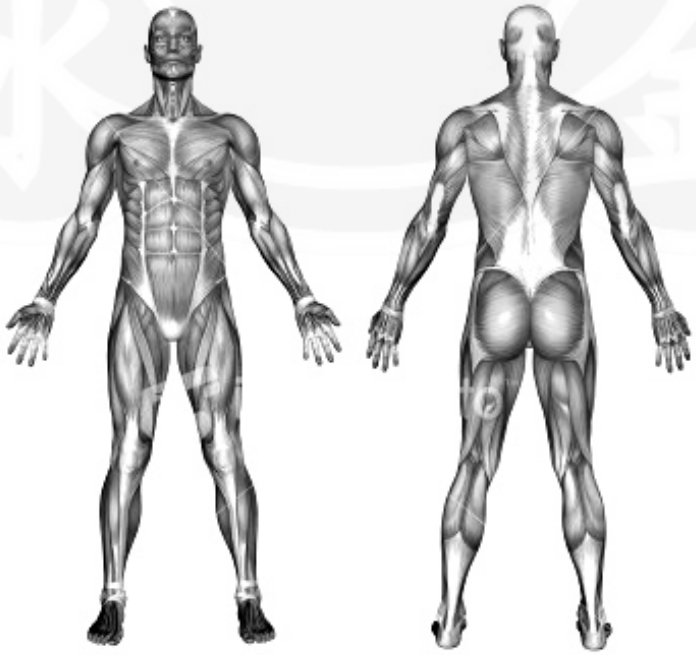
Do you frequently feel stressed? ❑Yes ❑No

How would you describe your current state of health? _____

When do you last remember feeling really great? _____

Are you currently pregnant or breastfeeding? ❑Yes ❑No

Please mark on the figures below where you are experiencing any discomfort, pain, or tension.



Are you currently under the care of any of the following medical professionals?

❑ Medical Doctor
❑ Chiropractor
❑ Acupuncturist
❑ Physical Therapist
❑ Naturopath
❑ Massage Therapist
❑ Nutritionist
❑ Psychiatrist
❑ Personal Trainer

Please check any that apply currently or that you have experienced recently:

Musculoskeletal System
❑ Arthritis
❑ Artificial Joints
❑ Broken Bones
❑ Bursitis
❑ Carpal Tunnel Syndrome
❑ Joint Pain
❑ Muscular Dystrophy
❑ Osteoporosis
❑ Pain All Over Body
❑ Plantar Fascitis
❑ Tendonitis
❑ Whiplash

Head & Senses
❑ Poor vision
❑ Poor hearing
❑ Tinnitus/Ears Ringing
❑ Dizzy/Lightheaded
❑ Heavy-headed
❑ Poor Concentration
❑ Poor Memory

Thirst
❑ Hydrated
❑ Thirsty, drink cold
❑ Thirsty, prefer hot
❑ Thirsty, but don't drink
❑ Not ever thirsty

Respiratory System
❑ Asthma
❑ Allergies
❑ Bronchitis
❑ Sinusitis
❑ Frequent Cold/ Flu

Immune System
❑ Cancer
❑ Chronic Fatigue
❑ Fibromyalgia
❑ Diabetes
❑ HIV/AIDS
❑ Lupus
❑ Lymphoma
❑ Thyroid disease

Circulatory System
❑ Atherosclerosis
❑ Edema
❑ Thrombosis
❑ Heart Attack
❑ High BP
❑ Low BP
❑ Stroke
❑ Varicose Veins
❑ Poor Circulation
❑ Cold Hands/Feet

Sleep
❑ Insomnia
❑ Excessive Sleep
❑ Difficult Falling
❑ Difficult Staying
❑ Vivid Dreams
❑ Nightmares
❑ Not Enough

Digestive System
❑ Change in Appetite
❑ Acid Reflux
❑ Diarrhea
❑ Constipation
❑ Cramps
❑ Ulcers
❑ Food Allergies
❑ Gall Stones
❑ Hepatitis
❑ Hemorrhoids
❑ Leaky Gut

Nervous System
❑ Alzheimer's
❑ Headaches
❑ Migraines
❑ Multiple Sclerosis
❑ Neuropathy
❑ Parkinson's
❑ Seizures
❑ Shingles
❑ Spinal Injury

Integumentary System (Skin)
❑ Burns
❑ Dermatitis
❑ Eczema
❑ Fungal Infections
❑ Impetigo
❑ Scars
❑ Rash
❑ Easy to Bruise
❑ Dry/Brittle Hair

Emotional System
❑ Depression
❑ Anxiety
❑ Worry
❑ Fearful
❑ Grief
❑ Longing
❑ Weepy
❑ Irritable
❑ Angry
❑ Joy
❑ Mania
❑ Difficulty Expressing

Female Reproductive System
❑ Irregular Menstruation
❑ Painful Menstruation
❑ PMS
❑ PMDD
❑ Difficult Conception
❑ Miscarriage
❑ Endometriosis
❑ Perimenopause
❑ Menopause
❑ Hysterectomy

Urinary System
❑ Frequent Urination
❑ Wake to Urinate
❑ Frequent UTI
❑ Kidney Stones
❑ Adrenal Fatigue

Diet & Lifestyle
❑ Poor diet
❑ Cigarettes
❑ Alcohol
❑ Marijuana
❑ Illicit Substances
❑ Sedative/No Exercise
❑ Excessive Exercise
❑ History of Eating Disorder
❑ Job Stress/Concerns
❑ Family Stress/Concerns
❑ Other Stress/Concerns

What seems to make you feel better?

What seems to make you feel worse?

Have you had any accidents, illnesses, injuries, surgeries, or traumas that have affected your health in such a manner that you've never been totally well since? ❑Yes ❑No

Please list with approximate date

Please list any medications, with dosages, that you are currently taking:

Please list any vitamins, minerals, and herbs, with dosages, that you are currently taking:

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Consent For Treatment

Please read the following statements, initial, and sign below in agreement and for consent to treatment:

_____ Kali Day LAc will always abide by the highest standards of safety for my ultimate wellbeing. I understand that every precaution shall be made in my best interest and that all information that I share in the treatment setting shall be confidential.

_____ In the event you are unable to make an appointment, 24 hours notice is respectfully requested. Late cancellations and missed appointments will be billed at half the original price of the service.

_____ To allow all patrons and practitioners the greatest sense of serenity, please turn off your cellular phone, or in the case of urgency, turn it to a non-audible mode.

_____ I hereby authorize Kali Day LAc to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following: (1) the insertion of various styles of sterile, one-time use acupuncture needles into my body at various depths and locations; (2) massage of the acupoints, channels, or related tissue; (3) moxabustion, a heat treatment using the herb arthemesa vulgaris; (4) homecare suggestions such as dietary changes or supplements, exercises, lifestyle recommendations, or referrals to other specialists.

_____ In each treatment session there are opportunities to ask questions pertaining to my treatment. I have a right to refuse any form of treatment. I understand the nature of the treatment and the risks and possible consequences involved with acupuncture. I understand that there is always a possibility of unexpected complications and that no guarantee can be made concerning the results of the treatment.

All information is voluntary and correct to the best of my knowledge and it is my responsibility to inform Kali Day LAc and Eugene Holistic Medicine of any changes during the course of my treatment.

_____ _____

Signature (or Guardian's Signature) Date